17) Increases due to increased costs or charges of a related party.

18) Any issues involving labor cost increases except for those allowed in Section VII B. of this Plan.

19) New services.

C. Issues involving the following MIRL (or ARPDL but not PGRPDL) items may be resolved through an AA under the procedures in Section VII of this Plan.

1) Changes in Medi-Cal case mix and outliers.

2) Inappropriate calculation of fixed and variable costs.

3) An error in the calculations.

4) Determination of whether or not a provider is exempt from the ARPDL.

5) Extraordinary and unusual events.

6) Labor costs as allowed under Section VII B. of this Plan.

7) Other causes of cost increases for costs which were economically and efficiently incurred for the necessary care of Medi-Cal inpatients, that are an increase on a per-discharge basis over the prior fiscal period and are not listed under B. as not being subject to an AAR.

8) The interim rate as it may be affected by changes resulting from items appealed under 1) through 7) above.

D. If a provider's cost based reimbursement is the lower of Section II A. 1) and A. 2) of this Plan and exceeds both the ARPDL and the PGRPDL, the providers' AAR and any subsequent appeal of the AA, must address both limitations in order to obtain relief for both limitations. If only the ARPDL is appealed, no further appeal rights will exist for the PGRPDL at any later date, except for an AAR on a tentative PIRL settlement that is issued later as a final PIRL settlement.

E. The procedures for requesting an AA of an ARPDL shall be as follows:

1) A request for an AA of the ARPDL or PGRPDL, which the

Department deems acceptable, shall be submitted within 90 days after notification of that limitation. These AARs must be postmarked or hand delivered on or before the 90th day after the postmark on the settlement notification letter. No extensions shall be granted. If a settlement letter from the Department contains settlements for more than one fiscal period, 120 days shall be allowed to file the AAR.

2) The AAR shall be submitted in writing to the Department and shall specifically and clearly identify each issue, the total dollar amount involved for each issue and the dollar amount of overlap among each issue. If the Department determines that additional data are needed, the provider shall have 60 days after written notification of the Department's request to supply it to the Department. No extension shall be granted.

3) The AAR need not be formal, but it shall be in writing and specific as to each issue in dispute, setting forth the provider's specific contentions as to those issues and the estimated amount each issue involves. If the Department determines that the request for any issue fails to state the specific grounds upon which objection to the specific issue is based, including the estimated dollar amount involved, the provider shall be notified that it does not comply with the requirements of this regulation and the issue cannot be accepted. If an issue is not accepted on this basis, the provider may not submit this issue as a formal appeal.

4) All AARs must be signed by an employee of the provider authorized by the provider to do so or by an authorized representative.

   (a) If the AAR is signed by an authorized representative, a signed statement of such authorization for each fiscal period must accompany the AAR signed by an appropriate employee of the provider.

   (b) Each AAR must have a declaration attesting to the validity of all statements contained in the AAR. The declaration shall be signed by an appropriate employee of the provider or an authorized representative.

5) For each issue other than those covered by one of the specific formulas in this Plan the provider must demonstrate either (a), (b) or all parts of (c) below:
   (a) Data that was incorrectly transferred as specified in Section VI B. 7) of this Plan.

   (b) An error was made in the rate calculation.

   (c) All costs for which additional reimbursement are being requested were:

      1. economically and efficiently provided for the necessary care of Medi-Cal inpatients.

      2. not already included in the ARPDL and/or PGRPDL, whichever limitation(s) is being appealed.

      3. not overlap with any other AAR issue, or if there were, all such overlap must be used to reduce any additional reimbursement which would otherwise have been granted.

6) The request shall contain all the appropriate data to allow the Department to determine if relief is needed and to do the relief calculation.

   (a) This may include, but is not limited to:

      1. All internal/external reports concerning each issue;

      2. All material presented to the hospitals' Governing Board concerning this issue;

      3. Medical records for Medi-Cal patients;

      4. Bank statements and canceled checks;

      5. All financial statements;

      6. Copies of contracts.

      7. Copies of proposed and/or actual budgets.

      8. The provider's suggested calculation for relief except for each issue specifically listed under Section VII below, the formula in this Plan must be used.

(b) All data submitted must be accompanied by one or more statements attesting that the data are true and correct signed by an individual with knowledge of the submitted data. More than one statement may be required if more than one data source is utilized.

(c) All data submitted may be audited by the Department.

7) One-time relief may be granted for extraordinary and unusual events.

(a) The criteria for one-time relief is any item which occurred in one fiscal period and is not normally expected to apply to all future fiscal periods and therefore the ARPDL is not adjusted each future fiscal period for this issue.

(b) Formula relief shall only be granted for issues which are expected to carry on to every future fiscal period.

(c) Any relief granted for allowable increases in employee hours per discharge shall be one-time relief for the first two fiscal periods and then formula relief during the third fiscal period.

8) The following steps are required by the Department for calculating relief:

(a) The provider shall clearly identify each issue and the estimated dollar amount of relief for each issue.

(b) The provider shall identify the specific cause of the increased costs.

(c) The provider shall calculate what reimbursement is already included in the ARPDL due to this issue (such as pass-throughs) and/or overlap from other AAR issues.

(d) The Department shall review the providers' figures on (a) and make any necessary corrections.

(e) The Department shall determine whether to grant one-time or formula relief or no relief.

9) If data or other items requested by the Department for evaluation of an AAR are not supplied within 60 days, the Department shall suspend further consideration of this issue. After written notification if the requested data are not supplied within 120 days, the Department shall deem the AAR rejected for all issues for which the Department requested data or other items, and the provider shall be precluded from raising the issues in a formal appeal.

10) The provider shall be notified of the Department's decision in writing within 90 days of receipt of the provider's written request for an AA or within 60 days of receipt of any additional documentation or clarification which was required by the Department, whichever is later. The request for an AA shall be deemed denied if no decision is issued within these time frames.

11) A change in cost based reimbursable costs as defined in Section II A. 1) and A. 2) of this Plan whether or not as a result of an audit appeals process, shall result in a redetermination of the PIRL, and shall not give rise to any additional appeal rights.

vII. SPECIFIC ADMINISTRATIVE ADJUSTMENT ISSUES

A. AAs for year-to-year changes in case mix and/or outliers under the ARPD (not the PGRPD) shall be resolved in the following manner:

1) The case mix adjustment factor (CMAF) shall be calculated using the following steps:

(a) the provider shall supply a listing for every Medi-Cal discharge that occurred during both the settlement fiscal period and the prior fiscal period, sorted in admission date order, and shall include as a minimum:

1. The patient's last name and first initial.

2. Medi-Cal I.D. Number.

3. The admission date.

4. The discharge date.

5. The principal diagnosis code.

6. The total amount of billed charges.

7. The DRG number.

8. The DRG weight. The same set of DRG groups and weights must be used for both settlement fiscal period and prior fiscal period data. If charges for a newborn were billed together with its mother, the newborns and the mother must be listed separately on this listing, each with their own DRG and weight.

9. The sum of the cost weights and the number of Medi-Cal DRG discharges on the list. The number of Medi-Cal DRG discharges on the list must equal or exceed the number of audited Medi-Cal discharges. The listing must include all Medi-Cal patients, which includes newborns that are not counted as Medi-Cal discharges.

(b) The sum of the cost weights for each FPE shall be divided by their respective number of Medi-Cal discharges (not the number of patients in the listing) to obtain the average DRG weight for each fiscal period.

(c) The settlement fiscal period average DRG weight shall be divided by the prior fiscal period average DRG weight to obtain the CMAF.

(d) DRG cost weights used in this Section may be any set used by Medicare during any part of either the settlement or prior fiscal period. The Department may also publish a set of Medi-Cal or California specific DRG cost weights, day outlier cutoffs and classifications as an option for the providers to use.

(e) Once a CMA is granted, each subsequent fiscal period ARPDL shall include a CMA (even if the adjustment is negative) and the provider shall supply all required data necessary to do the CMA calculation to the Department within 9 months after the end of each subsequent FPE. Failure to do so will result in a 20 percent reduction to the provider's current interim payments. If the data

is not received within 12 months of the end of the FPE, the interim payment reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent. If a provider does not supply the data prior to the issuance of the final settlement, the CMAF shall be calculated so as to remove the affect of all previous CMAFs by compounding the previous CMAFs and applying the result to decrease the settlement fiscal periods ARPD. The provider shall not be eligible for a CMAF for any fiscal period. However, if the tentative PIRL settlement is issued within 9 months of the end of the FPE and the case mix data has not yet been supplied, then a CMAF of 1.0 shall be used for the tentative PIRL settlement only.

The provider shall be given 30 days advance notice prior to applying any reductions in interim payments under this part of the plan.

(f) For noncontract hospitals, the DRG weights shall be modified by one of the following two methods:

1. All DRG weights for all patients transferred to other acute care hospitals after being stabilized will be multiplied by 0.4 (a 60 percent reduction).

2. All DRG weights for patients transferred to other acute care hospitals after being stabilized shall be adjusted as follows:

   a. For each patient transferred list the charges from the hospital they were transferred to.

   b. Divide each patient's charges at the provider's hospital by the patient's total charges (which includes charges from both the hospital they were transferred to and the hospital they were transferred from).

   c. Multiply the result of b. for each patient by their DRG weight to obtain a new weight to use in the CMAF calculation.

3. The provider shall choose which option it will use. If the provider fails to specify an option in their AAR, the Department shall use option 1 above.

4. Outlier calculations for these providers shall be adjusted by using the costs and days for the patients while they are at both providers, and using the same allocation formula in 1-3 above.

2) Additional reimbursement shall be granted to approximate a hospital's increases, on a per discharge basis, in the marginal cost of care beyond specified thresholds that are not already reimbursed for in the ARPDL, including the CMAF. AARs for additional reimbursement due to outliers (both cost and day outliers) shall be determined as follows:

(a) If the provider has received a CMAF for the settlement fiscal period, then the outlier relief shall be calculated by:

1. the hospital shall also include on the listing required under A. 1) above the following additional items:

a. The length of stay for each patient.

b. The outlier cutoffs, in terms of both days and costs, as determined in accordance with Medicare prospective payment rules and regulations for the applicable time period of each individual patient. However, wherever the Medicare formula uses a cost-to-charge ratio, the hospital specific cost-to-charge ratio shall be used. If the provider elects to use an alternative set of DRG weights published by the Department to calculate their CMAF, then the corresponding set of alternative outlier cutoffs must be used for each patient.

c. If a patient qualifies as a day outlier under the Medicare prospective payment definitions, or using the alternative cutoff when the alternative DRG weights are used, then the amount of allowable outlier payments shall also be listed. This amount shall be the MIRL

divided by the number of Medi-Cal patient days, times 80 percent, multiplied by the number of days over the day outlier threshold for each patient.

d. For patients that do not qualify as a day outlier, but do qualify as a cost outlier, the amount of costs over the threshold shall be listed and shall be calculated as follows:

(1) The outlier cost cutoff shall be the greater of:

a) A fixed dollar amount (adjusted for area wage levels) as defined in 42 CFR, Part 412.80(a)(ii)(A) for the appropriate service period.

b) 1.5 multiplied by the ARPD multiplied by the DRG weight for the patient.

(2) The total costs for each patient shall be the overall Medi-Cal cost to charge ratio calculated from the cost report multiplied by the charges for each patient.

(3) The amount over the cost outlier thresholds, which is step (2) minus step (1), shall be multiplied by 0.80.

e. The cost to charge ratio as determined from the cost report for both the settlement and prior fiscal period.

(1) If a patient qualifies as both a day and cost outlier, they shall be treated only as a day outlier.

(2) Sum the amounts calculated in 2) (a)1. c. and d. above and divide by the respective number of Medi-Cal discharges for each FPE.

(3) Relief shall be calculated by subtracting the prior fiscal period result of (2) from the settlement fiscal period result of (2).

(4) Once an outlier adjustment, in conjunction with a CMA, has been granted, it shall be included in all subsequent settlements even if it is a negative adjustment. Data necessary to do the outlier calculation shall be submitted each FPE within 9 months of the end of the FPE or current interim payments shall be reduced by 20 percent. If the data is not received within 12 months of the end of the FPE, the interim payments reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent.

The provider shall be given 30 days advance notice prior to applying any reduction on interim payments under this part of the Plan.

(b) If a provider has not elected a CMA, then relief for outliers shall be calculated as follows:

1. Providers shall provide lists containing the number of patients for every length of stay for both the settlement fiscal period and the prior fiscal period. For newborns not counted as separate Medi-Cal discharges, their days shall be added to their mother's.

2. The settlement fiscal period and prior fiscal period mean lengths of stay for all Medi-Cal patients shall be calculated by dividing total Medi-Cal patient days (including nursery days) by Medi-Cal discharges for each respective fiscal period.

3. Calculate the standard deviation of the length of stay for all patients in the prior fiscal period.

4. Compute 1.94 standard deviations of the mean length of stay in the prior fiscal period and add the result to the mean length of stay in the prior fiscal period.

5. Round the result in 4. above down to the next whole number to establish the outlier threshold to be used for both prior and